STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, November 1, 2, 3, 2011 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Survey Team: Avona Connell, RN TC Dottie Navetta, RN Gloria Reisert, MSW Census bed type: SNF/NF: 84 Total: 84 Census payor type: Medicare: 08 Medicaid: 52 Other: 24 Total: 84 Sample: 17 Supplemental sample: 12 These deficiencies also reflect State findings cited in accordance with 410 IAC	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	16.2. Quality review completed 11/7/11 Cathy Emswiller RN			
F0464 SS=E	The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation and interview, the facility failed to provide sufficient space in the Alzheimer unit dining room to allow access and/or removal of a resident in case of an emergency during 2 of 3 meal observations. This deficient practice affected 12 residents who ate in the unit dining room. (Residents #55, 57, 65, 66, 75, 77, 61, 78, 62, 58, 84 and 60). This deficient practice also had the potential to affect 14 of 30 other residents who currently ate in the unit dining room. Findings include: 1. During the supper observation on 11/1/2011 between 5:10 p.m. and 6:00 p.m., the following was observed: - 24 residents were eating in the Alzheimer unit dining room.	F0464	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitues an admission or agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or exectuted in compliance with state and federal laws. F464. Requirement of dining room and Activitiy room.It is the intent of the facility for all residents have a dignify and safe environment during meal times. 1. Corrective action taken: Only sufficient number of residents will eat in the dining room during all three meals, in order to provide sufficient space in the Alzheimer unit dining room. This will allow access and/or removal of a resident in case of an emergency. In addition some residents will be	12/03/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Table 1 had 8 residents at the rectangle table - 1 resident in a wheelchair was seated in front of the window at the head of the table (Resident #66). 3 residents in wheelchairs were seated along the left side of the table (Residents #77, 55 and 60). 4 residents were seated in regular chairs at the bottom of the table and along the right side of the table in front of a wall. - Table 3 had 4 residents and a family member seated at the square table. 3 residents [at the 3 o'clock (Resident #75), 6 o'clock (Resident #78) and 9 o'clock (Resident #62) positions] were seated in wheelchairs and the family member [seated to the left of the resident at the 6 o'clock position) and 1 resident (at the 12 o'clock (Resident #84) position] were seated in regular chairs. - 2 residents at Table 1 (Resident #77 and 55) and 1 resident at Table 3 (Resident #75) who were in wheelchairs were observed to have their wheelchair wheels intertwined. CNA #1 [certified nursing assistant] was observed with a supper tray in her hands and was unable to get past these 3 residents to give the resident at the head of Table 3 her tray. All 3 residents had to be moved in order for this aide to give the tray to that resident. Resident #84 also was observed to have to go around		removed from their wheelchair to a dining room chair to make it a dignify and safe environment because all residents dining in the Alzheimer unit dining room has the potential to be effected. Also, some residents will be move to the main dining room with adequate supervision. 2. Residents Identified: All residents dining in the Alzheimer unit dining room has the potential to be effected. 3. Measure taken: Unit Manager/Memory Care Facilitator will monitor daily as part of her QA ensuring we are providing a safe environment for the residents during their dining experience. DNS will in-serviced nursing staff on 400 hall on the safety of positioning from wheelchair to dining chair and moving residents to main dining room. In-Service will be completed on Nov 22, 2011. 4. How Monitored:CEO/DNS will monitor the above corrective actions and will be reviewed in Quarterly QA meeting. This will be accomplished everyday 3 times a day for a period of 2 weeks, once a day for 2 weeks, once a week for 5 months. If compliance not achieve action plan will be develop. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is December 3, 2011. .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Tables 3 and 4 in order to get out from her position due to the wheelchairs intertwining. - Table 4 had 3 residents seated at the square table - all 3 residents [seated at the 12 o'clock (Resident #58), 3 o'clock (Resident #61) and 6 o'clock (Resident #78) positions] were observed to be in wheelchairs. - The family member's chair at Table 3 was observed between the wheelchair of the resident at the 6 o'clock position at Table 3 and the wheelchair of the resident at the 3 o'clock position at Table 4 making it impassable to reach the residents sitting at the head of the Tables 3 and 4 without moving other residents. During an interview with LPN #1 at 5:40 p.m., she indicated that the staff did the best they could with such a small space. She also indicated that she too felt it would be difficult to get some of the residents out in case of an emergency. At 5:50 p.m., the Administrator and the Director of Nursing were shown the dining room and how the residents were seated. Both also agreed it would be difficult to get residents out in case of an emergency.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During the breakfast meal observation on 11/2/2011 at 8:20 a.m., the dining room tables were noted to have been re-arranged. LPN #1 indicated they had re-arranged the tables and felt this was better now. The following was observed: - the rectangle table by the wall that led to the corridor was observed to have the head of the table pushed up against the adjoining wall. 2 residents (Residents #57 and 65) were observed in wheelchairs along the left long side of the table close to the head of the table eating. An empty third place setting was also observed along this side of the table. The resident seated at the first place setting (Resident #57) was observed in constant motion trying to get past the other resident (Resident #65) who was still eating. She was unable to get past this resident and began to yell out. CNA #2 was observed to have to move the resident who was still eating in order to get the other resident out. An interview with CNA #2 at this time indicated that she and the other CNAs had also noticed that it was going to be difficult to get residents along that one side of the table out in case of an emergency. She also indicated that they felt the head of the table should not have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been pushed against the wall which cut off access to getting the resident out from that way. 3.1-19(v) 3.1-19(w)(4)(A) 3.1-19(w)(4)(B) 3.1-19(cc)(4)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review and interview the facility failed to ensure the clinical record was accurately documented and readily available upon request for a follow up blood sugar result. This deficiency affected 1 of 2 residents observed for blood sugar monitoring using a glucometer [machine used to test blood sugar] in a supplemental sample of 12. (Resident # 30) Findings include:	F0514	F 514: Records Complete/Accurate/Accessible. It is the intent of the facility for all clinical records are accurate documented and readily available upon request for a follow up blood sugar result. 1. Corrective action:In regards to residnet #30 another Accu Check was performed and recorded. Also, continue to be administer and recorded per MD orders. All residnets for Accu Check has the potential to be effected. 2. Residents Identified:100% audit of the records was completed on all residents requiring accu check	12/03/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 00 B. WING	11/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 11/01/2011 at 11:45 a.m., during the medication pass, observation of Resident # 30 indicated a blood sugar monitoring result of 357 (normal results 70-110 Internet source Life 123). On 11/01/2011, at 11:50 a.m., review of the current signed physician orders dated 09/27/2011 indicated, but were not limited to; a blood sugar result greater than 350 was to be re-checked in 2 hours. On 11/01/2011 at 2:00 p.m., in interview with Licensed Practical Nurse (LPN) # 2, she indicated the re-check results of Resident # 30 blood sugar was 251. Documentation was lacking on the Medication Administration Record (MAR) which showed the result. LPN # 2 indicated, she must have forgot to document the result and sign on the MAR. LPN # 2 retrieved the glucometer [machine used to test blood sugar] and scrolled down thru blood sugar results and could not find a number that matched the indicated result of 251. 3.1-50(a)(1) 3.1-50(a)(3)		per MD orders. None identified to have out of range results. There were no other residents affected. 3. Measure taken:All nurses will be in-serviced by Assure Rep on Nov 21st with new glucometers and recording practices, including but not limited to documentation expectation, and location. Documentation will be check daily by DNS and ADNS to ensure that all accu checks results are recorded per MD orders. 4. How Montitored:DON/ADON will check Glocumenters flow sheets documentation daily for 30 days, then weekly for another 30 days, and once a week for 4 months. ED/DNS will review these audits in the daily QA stand-up meeting; monthly QA meeting; and with Medical Direcotr at the Quarterly Meeting. If compliance not achieve action plan will be develop.	